

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE		REGISTERED DISTRICT 5151 REGISTER NUMBER 0314		1. NAME: FIRST Jack		MIDDLE Franqui		LAST IV		2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>		3A. DATE OF DEATH: MONTH 01 DAY 23 YEAR 2013		3B. HOUR Approx. 6:20 P							
NCHS		4A. PLACE OF DEATH: (Check one) HOSPITAL DOA <input type="checkbox"/> ER <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify): <input checked="" type="checkbox"/> Jail cell		4B. IF FACILITY, DATE ADMITTED: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		4C. NAME OF FACILITY: (If not facility, give address) Suffolk County Police Dept. 7th Prct., Shirley		4D. LOCALITY: (Check one and specify) CITY <input type="checkbox"/> VILLAGE <input type="checkbox"/> TOWN <input checked="" type="checkbox"/> Brookhaven		4E. COUNTY OF DEATH: Suffolk		4F. MEDICAL RECORD NO.		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO <input type="checkbox"/> YES <input type="checkbox"/>		4H. IF FACILITY, DATE ADMITTED: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>					
4C		5. DATE OF BIRTH: MONTH 12 DAY 14 YEAR 1986		6A. AGE IN YEARS: 26 yrs.		6B. IF UNDER 1 YEAR ENTER: months <input type="checkbox"/> days <input type="checkbox"/>		6C. IF UNDER 1 DAY ENTER: hours <input type="checkbox"/> minutes <input type="checkbox"/>		7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) West Islip, NY		7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:		7C. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:							
7A		8. SERVED IN U.S. ARMED FORCES? (Specify years) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A <input type="checkbox"/> No, not Spanish/Hispanic/Latino B <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano C <input checked="" type="checkbox"/> Yes, Puerto Rican D <input type="checkbox"/> Yes, Cuban E <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify)		10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be. A <input checked="" type="checkbox"/> White/Caucasian B <input type="checkbox"/> Black or African American C <input type="checkbox"/> Asian Indian D <input type="checkbox"/> Chinese E <input type="checkbox"/> Filipino F <input type="checkbox"/> Japanese G <input type="checkbox"/> Korean H <input type="checkbox"/> Vietnamese I <input type="checkbox"/> Native Hawaiian K <input type="checkbox"/> Guamanian or Chamorro M <input type="checkbox"/> Samoan N <input type="checkbox"/> American Indian or Alaska Native (specify) P <input type="checkbox"/> Other Asian (specify) S <input type="checkbox"/> Other (specify)		11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 <input type="checkbox"/> ≤ 8th grade 2 <input type="checkbox"/> 9th-12th grade, no diploma 3 <input checked="" type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate's degree 6 <input type="checkbox"/> Bachelor's degree 7 <input type="checkbox"/> Master's degree 8 <input type="checkbox"/> Doctorate/Professional degree		12. SOCIAL SECURITY NUMBER: 119-76-5371		13. MARITAL STATUS: NEVER MARRIED <input checked="" type="checkbox"/> 1 MARRIED <input type="checkbox"/> 2 WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/> 4 SEPARATED <input type="checkbox"/> 5		14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.		15. USUAL OCCUPATION: (Do not enter retired) Cook		15B. KIND OF BUSINESS OR INDUSTRY: Food		15C. NAME AND LOCALITY OF COMPANY OR FIRM: American Red Cross	
SI		16A. RESIDENCE: (State or Country if not USA) New York		16B. County or Region/Province if not USA: Suffolk		16C. LOCALITY: (Check one and specify) CITY <input type="checkbox"/> VILLAGE <input type="checkbox"/> TOWN <input checked="" type="checkbox"/> Brookhaven		16D. STREET AND NUMBER OF RESIDENCE: 83 Magnolia Dr. Rocky Point		16E. ZIP CODE: 11778		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN.		16G. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN.							
25		17. BIRTH NAME OF FATHER / PARENT: FIRST Joaquin MI Franqui LAST Phyllis		18. BIRTH NAME OF MOTHER / PARENT: FIRST Phyllis MI Daily LAST Daily		19A. NAME OF INFORMANT: Joaquin Franqui		19B. MAILING ADDRESS: (Include zip code) 83 Magnolia Dr. Rocky Point, NY 11778		20A. 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL 4 <input type="checkbox"/> HOLD 5 <input type="checkbox"/> DONATION MONTH 01 DAY 28 YEAR 2013		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Washington Memorial Park Mount Sinai, NY		20C. LOCATION: (City or town and state)							
31		21A. NAME AND ADDRESS OF FUNERAL HOME: Branch Funeral Home 551 Route 25 A Miller Place, NY 11764		21B. REGISTRATION NUMBER: 00208		22A. NAME OF FUNERAL DIRECTOR: John H. Vigliante		22B. SIGNATURE OF FUNERAL DIRECTOR: 		22C. REGISTRATION NUMBER: 13688		23A. SIGNATURE OF REGISTRAR: 		23B. DATE FILED: MONTH 01 DAY 28 YEAR 2013							
31B		24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Mary Dugan		24B. DATE ISSUED: MONTH 01 DAY 27 YEAR 2013		25. DATE OF DEATH: MONTH 01 DAY 23 YEAR 2013		26. DECEASED LAST SEEN ALIVE BY ATTENDING PHYSICIAN: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		26C. Pronounced: MONTH 01 DAY 23 YEAR 2013		26D. TIME: 7:50 P		26E. TIME: 7:50 P							
OR		27. MANNER OF DEATH: NATURAL CAUSE <input type="checkbox"/> 1 ACCIDENT <input type="checkbox"/> 2 HOMICIDE <input type="checkbox"/> 3 SUICIDE <input checked="" type="checkbox"/> 4 UNDETERMINED CIRCUMSTANCES <input type="checkbox"/> 5 PENDING INVESTIGATION <input type="checkbox"/> 6		28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29A. AUTOPSIES? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29C. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29D. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29E. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES							
OS		29. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) HANGING DUE TO OR AS A CONSEQUENCE OF: (B) DUE TO OR AS A CONSEQUENCE OF: (C)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):		DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN		31A. IF INJURY, DATE: MONTH 01 DAY 23 YEAR 2013		31B. INJURY LOCALITY: (City or town and county and state) Shirley, Suffolk, N.Y.		31C. DESCRIBE HOW INJURY OCCURRED: HANGED SELF							
OCOD		31D. PLACE OF INJURY: JAIL CELL		31E. INJURY AT WORK? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		33A. IF FEMALE: <input type="checkbox"/> Not pregnant within last year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Unknown if pregnant within past year		33B. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33C. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33D. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>							
CANCER		33E. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33F. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33G. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33H. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33I. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33J. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		33K. DATE OF DELIVERY: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>							

For use by physician or institution:
NAME OF DECEASED: **Jack Franqui**
DATE OF DEATH: **01/23/2013**
TIME OF DEATH: **7:50 P**